

**SECTION**  
GENERAL PROGRAM ADMINISTRATION

**SUBJECT**  
Principles of Charting

**CHARTING REQUIREMENTS**

This section addresses the minimal charting requirements.

1. All entries must be legible and in ink;
2. Errors are corrected by drawing a single line through the error, writing the word "error" above it, initialing it, and then writing the correct entry. NEVER erase, draw multiple lines through an error or use correction fluid;
3. Ditto marks must not be used;
4. Each page should have the individual's name on it;
5. The full date of each entry must be recorded;
6. Each entry must end with the signature or initial of the person making the entry; and
7. Entries should be made in sequence. If it is necessary to make a late entry, indicate the date of the late entry and the date of the occurrence. For example, 07/30/08 charting for 07/28/08.

**RULES OF CHARTING**

1. Do not sign entries of any kind for another person. It is permissible for one person to chart when both team members visit the individual, but both team members should sign or initial the entry; and
2. Do not chart before an event occurs.

**CHART CONTENTS**

1. Record pertinent observations, psychosocial and physical manifestations, incidents, any unusual occurrences or abnormal behavior;
2. Chart facts, what is seen, heard, felt and smelled. Make objective rather than subjective statements and avoid making generalizations, vague comments and opinions. For example, (objective statement) Less talkative than yesterday. Taking medications as prescribed. (Subjective) Quiet and cooperative;
3. Record approaches to correcting problems identified in the individual Person-Centered Recovery Plan;

**SDMI HCBS 306**  
**Department of Public Health and Human Services**  
**MENTAL HEALTH SERVICES BUREAU**

**SECTION**  
GENERAL PROGRAM ADMINISTRATION

**SUBJECT**  
Principles of Charting

4. Record all teaching efforts, including instruction given to the individual's family;
5. Record an opening statement when a individual is enrolled and a closing statement when a individual is discharged from services; and
6. Record the type of contact; e.g., telephone call, office visit, home visit, etc., and specifically identify who made the contact.

